tumor at the level of the 7th dorsal vertebra. In all three cases plantar flexion of the big toe, generally but not so regularly, with the same movement of the other toes and extension of the knee, was observed on stroking the thigh.

He further recalls that apparently simultaneously v. Strümpell had published a number of observations (on paraplegics) in which, by irritation of the sole of the foot and the leg, the ordinary flexion reflex was observed, whereas irritation of the skin of the thigh—generally by stroking with the handle of the percussion-hammer, but at times by pricking or by the application of cold—a contraction of the thigh muscles, particularly the quadriceps and the adductors of the hip, was brought about.

These observations did not agree with his own, in that, in his experience, plantar flexion of the first toe occurred much more commonly than the contraction of the quadriceps femoris; and the matter was of particular interest to him because it concerned cases in which irritation of the sole of the foot always brought about the now much-exploited Babinski plantar reflex of the toes.

Remak then reports a case of a 2½-year-old child with spastic paraplegia from Pott's disease involving the region of the 3d and 4th dorsal vertebræ. There was slight rigidity of the legs, the knee-jerks and Achilles phenomenon lively, with ankle-clonus at times. The sensation of the lower extremities seemed diminished. Irritation of the sole of the foot caused extension of the great toe, then dorsal flexion of the foot-joint and flexion of the thigh on the pelvis. On the other hand, stroking of the upper anterior portion of the thigh with the handle of the percussion-hammer or with the head of a pin invariably caused plantar flexion of the first three toes, more rarely an extension of the knee. By stronger irritation flexion of the thigh on the pelvis immediately occurred.

In conclusion, R. states it as his impression that the femoral reflex involves the quadriceps more regularly and to a more marked degree in the lower-lying cord lesions (region of 8th dorsal segment), whereas in higher compression only plantar flexion of the toes is brought out, and that it is not improbable that not only the localization of the break in conduction but also its intensity plays a rôle.

J. W. COURTNEY.

53 THE OCCURRENCE OF DAY-TERRORS IN CHILDREN. G. F. Still (Lancet, Feb. 3, 1900).

Day-terrors in children have received but little attention. Much has been written of night-terrors, as they are common, but little attention has been given to the much less common attacks which occur during the waking moments. The author reports five cases of this condition, occurring in children all under the age of six years. In most of the cases the child suddenly begins to scream, has a terrified look and runs to his mother or attendant, hiding his face, and gives evidence of suffering from great fear. Hallucinations and delusions seem to be absent. Cases are reported which have occurred in older children. In some of these distinct evidences of visual and auditory hallucinations were obtainable. The relation to night-terrors is probably very close. In four of the cases reported night-terrors were, or had been, present and it would seem that the day attacks may be associated with them or replace them; but the two conditions are probably very different in etiology, although the etiology of night-terrors is far from being known. A nervous, excitable temperament is nearly always a factor in the etiology. Rheumatism, either in the child or in the parents, may play some rôle. In most of these children minor functional neuroses are evident. Habit spasms, nocturnal enuresis, recurring headaches, nervous diarrheas, are frequent with them. In a large number valvular disease is present. Some observers have claimed that night-terrors, and more particularly day-terrors, are epileptic in their nature, and that the condition is to be considered as a form of *petit-mal*. This is not the view held by the author. He believes that, inasmuch as these patients do not show any tendency to attacks of major epilepsy, and, furthermore, are so readily relieved of their symptoms by appropriate treatment, that the relation to epilepsy must be but very slight, if any relationship at all exists. In some cases there seems but a very narrow line existing between day-terrors and some forms of insanity. The author's summary of impressions—for thus far in the study of this affection it is only possible to have impressions—is that it is a paroxysmal psychoneurosis allied to, but not identical with, epilepsy on the one hand and hysteria and insanity on the other. The prognosis is good. The most important part of treatment is the removal of any exciting cause. Since a chronic intestinal catarrh is apt to be present, it should be relieved. Potatoes, pastry and the sugars are to be excluded from the diet. Thread worms or other intestinal parasites must be removed. Potassium citrate and the bromides are useful, and a regular mode of life with healthful distractions and non-exciting sports will usually aid materially in the treatment. JELLIFFE.

54 SUR LES ATROPHIES MUSCULAIRES PROGRESSIVES D'ORIGINE MYELOPATHIQUE (On Progressive Muscular Atrophy of Myelopathic Origin. G. Etienne (Nouvelle Icon. de la Salpêtrière, Sept., Oct., 1899).

G. Etienne reports six cases of muscular atrophy of myelopathic origin. These cases are of interest because they depart in some details from the classic description of this disease, but yet they bear such a general resemblance to one another that they evidently belong to the same group. In a general way progressive muscular atrophy of myelopathic origin, or anterior chronic poliomyelitis, or Duchenne-Aran disease, is characterized clinically by the following six points: 1. Onset in the upper extremities. 2. Fibrillary tremor. 3. Reaction of degeneration. 4. Absence of heredity. 5. Commencement at a late adult age. 6. Chronic evolution, about four or five years. The anomalies observed in these cases were: 1. Rapidity of evolution. 2. Early commencement. 3. Modes of onset. 4. Rare complications, as arthropathies. 5. Presence of heredity. Each of the cases quoted illustrates one of these varieties. In the first case, instead of the usual chronic evolution, that is, from three to six years, the whole process was completed in eighteen months after the first manifestations of the disease. In the second case, instead of the usual age, that is, from forty to sixty years, the patient was twenty-four years old at the time of the first symptoms of the disease, which were fatigue conditions in the small muscles of the hand. This patient had had an infantile paralysis involving the right leg. As a rule, the disease begins in the small muscles of the hand, generally the right. The thenar and the short abductor of the thumb are commonly affected first. In the third patient the deltoid and the periscapular muscles showed the first symptoms. The fourth patient had infantile paralysis in the first year of life. The beginning of the present process was in the paralyzed leg and in the muscles of the forearm. The fifth case showed a hereditary history of myelopathic affections. This is very rare in this form of muscular atrophy, but common in myopathic varieties. The sixth case showed the rare condition of arthropathy